Retina Associates of Western NY, P.C.

Preserving and restoring sight with compassion and innovation

Patient Authorization for Release of Medical Records

Processing fee: $10 per OCT photo, $15 per Fluorescein Angiogram

Patient's Name: _____

Address: _____

Please check all information that applies:

❒ Chart Notes
❒ MRI Report
❒ X-Rays
❒ CAT Scan
❒ Other (please specify): _____

Please include dates: _____

❒ I give my authorization to release the above protected information to Retina Associates of Western NY, P.C.

❒ I am authorizing Retina Associates of Western NY, P.C. to disclose or release the above protected information to the following person or organization. The following will receive and use my protected health information:

Name: _____

Address: _____

Fax Number: _____

Select one of the following choices:

❒ This authorization will end on the following date: _____

❒ This information will end when the following event happens. The event must relate to the individual or the purpose of the authorized use or disclosure. Describe the event below:

Signature of Patient:

Name of Patient:

Date: